DEPARTMENT OF PUBLIC HEALTH AND WELLNESS

KCP Kentucky Cancer Program

the Cooper Clayton Method to Stop Smoking

Participant History

Name: _____
Last First Middle or Maiden

Home Address: Street_____City/State/Zip_____

Home Phone: (_____) _____- _____Cell Phone (_____) _____- _____

Email Address: _____ Date of Birth: _____/_____/_____
Month Day Year

Place of Employment: _____ Occupation: _____

Gender: ☐ Male ☐ Female Race: ☐ African American ☐ Hispanic ☐ Caucasian ☐ Other

1. What is the highest level of education you have completed?
   ☐ Some High School or Less ☐ High School Diploma or GED ☐ Technical School/Associate Degree
   ☐ College Degree or Higher ☐ Other (please specify) _____

2. What medical insurance do you have? (check all that apply) ☐ No Insurance ☐ Private Insurance
   ☐ Medicaid ☐ Medicare ☐ Veterans Benefit ☐ Other

3. How did you find out about this program? (check all that apply) ☐ Newspaper ☐ Radio ☐ Physician
   ☐ Family/Friend ☐ Employer ☐ Other (please specify) _____

4. Why did you decide to take this class? (check all that apply)
   ☐ Personal Health Issues/Poor Health ☐ Family Health ☐ Smoking Bans ☐ Cost of Tobacco ☐ Other

5. Have you taken "Cooper Clayton Method to Stop Smoking" classes in the past? ☐ Yes ☐ No

6. How many years have you smoked? ☐ Less than 5 ☐ 5-15 ☐ 16-25 ☐ 26-35 ☐ 36 or More

7. How many times have you tried to stop smoking (before this class)? ☐ 1-5 ☐ 6-10 ☐ 11 or More

8. Did you use tobacco products other than cigarettes before this class? (check all that apply)
   ☐ Smokeless Tobacco ☐ Cigar ☐ Pipe ☐ Other (please specify) _____

9. What type of Nicotine Replacement Therapy or medication have you used? (check all that apply)
   ☐ Nicoderm Nicotine Patch ☐ Nicotine Lozenge ☐ Nicotine Gum ☐ Inhaler
   ☐ Chantix ☐ Wellbutrin (Zyban SR) ☐ Other (please specify) _____

10. Have you had a reaction to any Nicotine Replacement Therapy medication? (Check One) ☐ Yes ☐ No
    Which one?_____

11. May we contact you during or after the program to follow your progress?
(Check One) ☐ Yes ☐ No

If yes, please provide the contact information of a friend or relative who can tell us how to contact you in the next year.

Name: _____ Relationship: _____

Address: Street_____ City/State/Zip: _____

Phone: (_____)_____-_____ Email: _____

Fagerstrom Nicotine Dependence Test

1. How soon after you wake in the morning do you smoke your first cigarette?
   - Within 5 minutes _____ (3 points)
   - 6-30 minutes _____ (2 points)
   - 31-60 minutes _____ (1 point)
   - After 60 minutes _____ (0 points)

2. Is it hard not to smoke where smoking is not allowed? (at church, hospital, bus, library, or movie theater, etc.)
   - Yes _____ (1 point)
   - No _____ (0 points)

3. Which of all the cigarettes you smoke during the day is the most satisfying?
   - First one in the morning _____ (1 point)
   - All others _____ (0 points)

4. How many cigarettes a day do you smoke?
   - 10 or less _____ (0 points)
   - 11-20 _____ (1 point)
   - 21-30 _____ (2 points)
   - 31 or more _____ (3 points)

5. Do you smoke more in the morning than the rest of the day?
   - Yes _____ (1point)
   - No _____ (0 points)

6. Do you smoke when you are sick enough to have to stay in bed?
   - Yes _____ (1 point)
   - No _____ (0 points)

Total Fagerstrom Score: _____